Be *'pro-active'* but reflect on lessons from exercise referral schemes

It was pleasing to hear delegates were pro-active living and recognised its importance to population health and well-being. This commentary draws upon broader themes from across the seminar, and poses questions within the specific context of exercise referral schemes (ERS), to encourage wider ongoing discussion. ERS, popular since the 1990s, typically allow health professionals to refer inactive individuals with chronic conditions to a third party leisure provider for a supervised exercise programme, aimed at increasing physical activity.

An important theme, first raised by Dr Michael Dixon, was the need for 'better' evidence. Unlike most areas of social prescription, NICE provide evidence-based guidelines for ERS. However, the evidence-base has been criticised for slow growth, few RCTs, and insufficient assessment of what works, how and for whom. To this end, despite the indisputable benefits of physical activity, researchers and practitioners are concerned about the increasing likelihood of decommissioned ERS, particularly under austerity. This stark reality contrasts the enthusiasm displayed during the seminar. Is it a good thing that there are no NICE guidelines for social prescription which may threaten wider implementation or discourage referrals, if similar conclusions are drawn?

The third panel discussion suggested 'harder', quantitative and economic evaluation are necessary to make social prescription mainstream. We must ensure, however, that whilst demonstrating positive health outcomes, social prescription is not underpinned by the traditional biomedical evidence paradigm that has long inhibited public health and widens health inequality. Dr Dixon conveyed plans for a common evaluation framework. There has been a physical activity-specific standard evaluation framework for six years. It is seldom-used and criticised for not capturing complexity in physical activity promotion. How can we ensure such shortcomings do not befall broader social prescription? How can we incentivise and embed use in daily working?

Within ERS, increasing research suggests schemes benefit from co-development with local stakeholders, including commissioners, service providers, health professionals and importantly service users. Here, we should heed the words of Rob Wester and his Rt. Hon. the Lord Howarth of Newport and *"see the person"* and *"get better at endorsing the voices of whom we are working for."* This will require qualitative evidence of how and why schemes work or otherwise, and for whom. In turn, it may facilitate understanding complexity in social prescription and promote contextually relevant evidence-based practice.

NICE's ERS guidance dictates schemes may only be commissioned for patients with long-term health conditions, or those overweight with at least one additional health risk. This resonates with a concern held by many at the seminar and discussed during the final panel session: *"Are we at risk of excluding many potential beneficiaries of social prescription with a dominant focus on chronic conditions?"* Naturally, greatest economic impact need be considered, particularly under austerity, but this is further advocacy for a Health Service that promotes wellness through preventive measures and not merely treats illness. There are likely many who are seemingly in 'good' health but could benefit from schemes if given the opportunity to maintain or improve their health status, and would lack the motivation, skills or access to otherwise do so. How can we demonstrate that social prescription can be for everyone, not just the niche groups for whom it is often deemed appropriate?

Finally, there was considerable discussion about the term ‘prescription’. Dr Dixon defended it as a term of reference against which the concept and aims of social prescription may be understood. There is physical activity research evidence to suggest, that the term adds legitimacy to a course of action from trusted figures like GPs, that ERS is not yet afforded. For example, New Zealand incorporate physical activity into their ‘green prescriptions’. How can terminology be used to add weight to our efforts here?

Whilst concerned about references to commercialised physical activity, it was welcoming to see physical activity at the forefront of England’s health agenda and long may this ‘pro-active’ approach to social prescription grow and prosper.

Author profile

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